

APPENDICES: State of Connecticut: Implementation Support for State Demonstrations to Integrate Care for MMEs

Appendix A: Budget

State Admin. & Oversight

Position/Role	# of Positions	Average Salary	Benefits/Indirect Costs (est. at 38% of salary)	Total Expense
Project Coordinator	1.00	\$75,000	\$28,500	\$103,500
Project Assistant	1.00	\$75,000	\$28,500	\$103,500
Accounting/Fiscal Staff	2.00	\$75,000	\$28,500	\$207,000
Total	4.00	\$300,000	\$114,000	\$414,000

Year 2 Salary Trend: 3%

Year 1 Estimated Expense	Year 2 Total Estimated Expense	Year 2 State Share @ 25%	2-Year Total Funding Request
\$103,500	\$106,605	\$26,651	\$183,454
\$103,500	\$106,605	\$26,651	\$183,454
\$207,000	\$213,210	\$53,303	\$366,908
\$414,000	\$426,420	\$106,605	\$733,815

External Contractor

Contractor	Area of Responsibility	Detail
JEN Associates	Data Integration	Seven user licenses to access linked Medicare/Medicaid dataset
Mercer	Actuarial/Financial Services	Actuarial services
HP	MMIS	System modifications to support reimbursement and data warehouse reporting for APM I and APM II
Xerox	Enrollment	Member enrollment in the health neighborhoods
Ombudsman Services	Appeals and Consumer Support	Assists Consumers in navigating appeals and serves as a general point of assistance for consumer affairs
Program Evaluator	Performance Measures and Program Evaluator	Performance assessment of health neighborhoods against

Year 1 Estimated Expense	Year 2 Total Estimated Expense	Year 2 State Share @ 25%	2-Year Total Funding Request
\$220,000	\$220,000	\$55,000	\$385,000
\$745,000	\$425,000	\$106,250	\$1,063,750
\$696,000	\$348,000	\$87,000	\$957,000
\$730,000	\$200,000	\$50,000	\$880,000
\$312,500	\$625,000	\$156,250	\$781,250
\$100,000	\$100,000	\$25,000	\$175,000

		contract standards for care coordination
Marketing materials	Mailing	
Design assistance for HNs Year 1	HN support	
EHR swipe card vendor costs	HN support	
Electronic Care Coord Tool development	CHN ASO	Predictive modeling
Model 1 ICM — Enhanced ASO, including start up	CHN ASO	Staff — direct, fringe, and indirect
Total		

\$100,000	\$75,000	\$18,750	\$156,250
\$125,000	\$0	\$0	\$125,000
\$200,000	\$800,000	\$200,000	\$800,000
\$250,000	\$0	\$0	\$250,000
\$1,449,782	\$3,037,491	\$759,373	\$3,727,900
\$4,928,282	\$5,830,491	\$1,457,623	\$9,301,150

Health Neighborhoods (HN)

Contractor	Start Up Expenses	Administration (annual cost)	Year 1 Supplemental Services ¹	Year 2 Supplemental Services
HN 1	\$250,000	\$104,650	\$30,833	\$127,033
HN 2	\$250,000	\$104,650	\$30,833	\$127,033
HN 3	\$250,000	\$104,650	\$30,833	\$127,033
HN 4	\$250,000	\$104,650	\$30,833	\$127,033
HN 5	\$250,000	\$104,650	\$30,833	\$127,033
Total	\$1,250,000	\$523,250	\$154,167	\$635,167

Year 1 Estimated Expense ²	Year 2 Estimated Expense	Year 2 State Share @ 25%	2-Year Total Funding Request
\$359,321	\$233,776	\$58,444	\$534,653
\$359,321	\$233,776	\$58,444	\$534,653
\$359,321	\$233,776	\$58,444	\$534,653
\$359,321	\$233,776	\$58,444	\$534,653
\$359,321	\$233,776	\$58,444	\$534,653
\$1,796,604	\$1,168,882	\$292,220	\$2,673,265

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 2 @ 25% State Share</u>	<u>2-Year Total</u>
Total Expenditures	\$7,138,886	\$7,425,793	\$1,856,448	\$12,708,230

Notes

Year 1 is defined as the anticipated award date (Aprx July 1, 2013) through June 30, 2014

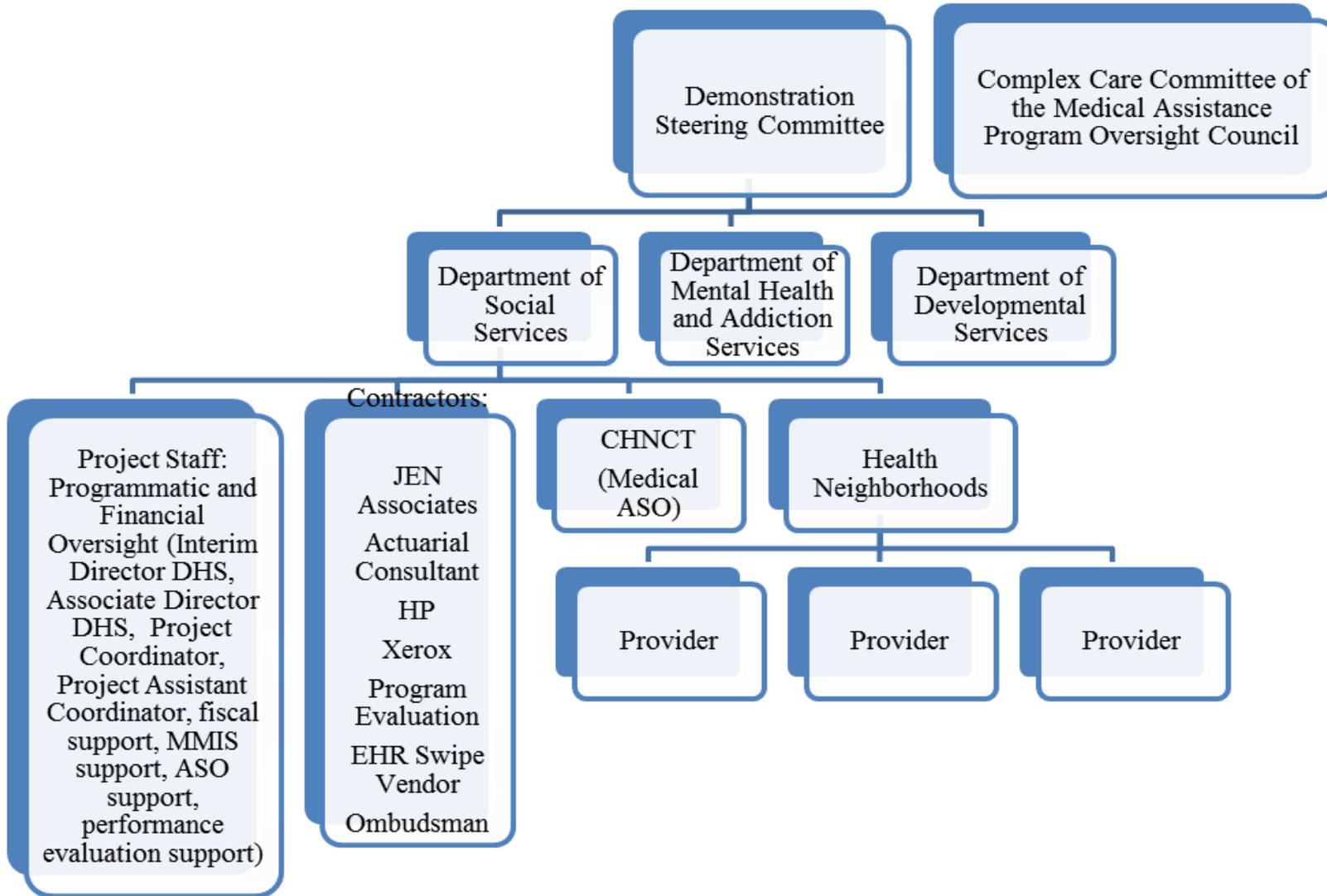
Year 2 is defined as July 1, 2014 through June 30, 2015

Footnotes

1. Year 1 expense includes only 3 months of Supplemental Services

2. Year 1 expense includes only 9 months of HN administrative costs

Appendix B: Organizational Chart



Appendix C: Definitions (excerpts from draft Operating Plan documents)

- **Assessment:** For purposes of the Demonstration, an Assessment is a comprehensive, multi-dimensional assessment of domains including functional capacity, physical and cognitive status, formal and informal supports, and environment, which is used to prepare a Plan of Care.
- **Care Coordination:** Care coordination is a person-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which an individual's needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an identified care coordinator following evidence-based standards of care. Care coordination support is offered to MMEs along a continuum from minimal level of assistance to intensive level of assistance, as described by the following:
 - **Level 1 Targeted Outreach:** Targeted Outreach is a brief, focused support focused upon MMEs with unmet or underserved medical, behavioral health, LTSS or social support needs who either 1) are not at high risk; or 2) prefer to self-direct their own services and supports. This service can be provided either by a Lead Care Manager or can be delegated as appropriate to an extender (e.g. care manager assistant, community health or outreach liaison). Non-exclusive examples of Targeted Outreach include 1) assistance in identifying and scheduling appointments with specialists; 3) referrals to social services and supports; and/or 4) support with general information & assistance inquiries. Key goals of targeted outreach include providing needed information and improving access to services and supports.

- **Level 2 Care Management:** Care Management is a periodic, intermittent support focused upon MMEs with unmet medical, behavioral health, LTSS or social support needs who are at moderate risk. This service must be provided by a Lead Care Manager. Non-exclusive examples of Care Management activities include 1) assessment of needs to identify unmet or underserved needs; 2) engagement with the MME and members of the MME's care team to support access to needed care, assist with chronic disease self-management, and promote medication compliance; and 3) coordinate services for planned care transitions (e.g. scheduled surgery or other acute treatment). Key goals of Care Management include 1) preserving and/or improving function; 2) preventing exacerbation of presenting conditions; 3) averting crises; and 4) diverting MMEs from use of emergency departments, inpatient hospitalization and re-hospitalization, and long-term nursing home placement.
- **Level 3 Intensive Care Management:** Intensive Care Management (ICM) is an ongoing support focused upon MMEs with unmet medical, behavioral health, LTSS or social support needs who are at high risk. This service must be provided by a Lead Care Manager. Examples of ICM activities include assistance in 1) assessment of needs to identify priorities; 2) engagement with the MME and members of the MME's care team to develop near term goals relating to acute/urgent care, coordination of services across the continuum of services and supports, and chronic disease self-management; 3) coordinate services for unplanned transitions; and 4) intervene with patterns of hospitalization and re-hospitalization, and/or inappropriate nursing home placement. Key goals of ICM include 1) stabilizing the MME's health condition; 2) achieving smooth

care transitions and means of monitoring needs over time; and 3) improving the MME's capacity to self-manage chronic conditions.

- **Multi-Disciplinary Care Team:** For purposes of the Demonstration, a Multi-Disciplinary Care Team (Care Team) is defined as including an MME who is participating in the Demonstration, his/her representatives, his/her LCM and extender staff, and the group of HN provider members who are mutually supporting the needs, values and preferences of that MME. Each Care Team is led by the MME and his/her LCM, and is composed of all relevant provider members of the HN, as well as any involved Information & Assistance Affiliates and Social Services Affiliates.
- **Plan of Care (POC):** For purposes of the Demonstration, a Plan of Care is defined as a document that is completed by a Lead Care Manager in partnership with an MME and his/her chosen representatives, which articulates the MME's goals, provides an inventory of the services that are being received by the MME, identifies the members of the MME's care coordination team, and includes action steps (e.g. toward improving communication and collaboration among MME and members of the care coordination team, effectively managing chronic disease, and preventing unnecessary hospitalization and/or nursing home placement).
- **Lead Care Manager (LCM):** An LCM is responsible for assessing, coordinating and monitoring an MME's Demonstration Plan of Care (POC) for medical, behavioral health, long-term services and supports (LTSS), and social services. A Lead Care Manager must be an APRN, RN, LCSW, LMFT or LPC and must complete Demonstration specific training.
- **Lead Care Management Agency (LCMA):** A LCMA is a Medicaid enrolled provider member of a Health Neighborhood that employs staff that meet requirements to serve as LCMs.

Appendix D: Performance Measures:

A. Performance Measures from Washington State's MOU

Connecticut anticipates that the performance measures from Washington State's MFFS MOU will be included in our MOU with CMS, including Model Core Measures (such as all cause hospital readmissions, depression screening and follow up) and State-Specific Measures (such as discharge follow-up, with adaptation of terminology for Connecticut's Demonstration). Also as in Washington's MOU, in order to assess beneficiary experience, we anticipate that the MOU will include that the State will work with CMS and its contractors to implement beneficiary and caregiver surveys.

B. State-Specific Measures:

In addition to monitoring the above measures and selecting the required 3 to 5 "state-specific demonstration measures", which we anticipate will be used by CMS in determining retrospective performance payments (shared savings) the Department and the program evaluator will develop a monitoring plan that will include a more comprehensive set of performance measures. These measures will focus on areas identified by stakeholders as priorities (as in our May 2012 application), especially in areas not explicitly addressed by the above measures (such as diabetes care, medication therapy management, and quality of life). We are especially interested in selecting measures from among existing developed measures, as used in relevant measure sets such as:

- The National Quality Forum's 2012 report: "Measuring Healthcare Quality for the Dual Eligible Beneficiary Population: Final Report to HHS";
- Medicare Accountable Care Organizations' quality measures;
- Measures already monitored by CHNCT for our current health care programs

Appendix E: Draft Implementation Plan:

	Task Name	Start	Finish	Resource Names	Agency Partner
1.	JEN contract renewal and data analysis			K. McEvoy,	K.
	a. JEN contract renewal	4/1/13	4/29/13	R. Weiser	Brennan,
	b. Obtain and integrate Medicare-Medicaid 2011 data and monthly files	5/1/13	6/30/13	(DSS)	U.
	c. Update cluster analysis to identify potential HN sites	5/1/13	7/10/13		Ganesan,
	d. Perform additional analysis of data (client characteristics, etc)	5/1/13	8/15/13		L. Voghel
	e. Work with JEN to house integrated data within DSS	8/1/13	10/15/13		
2.	Health Neighborhood (HN) Requirements/Definitions			K. McEvoy,	DMHAS,
	a. Develop internal flow/design document for HNs	4/1/13	5/25/13	R. Weiser,	DDS,
	b. Develop, solicit feedback on, and finalize operating plans for HN	2/1/13	6/1/13	B. Halsey	CCC, D.
				(DSS)	Parrella
					(Mercer)
3.	Beneficiary Protections			B. Parrella	CMS,
	a. Design mechanism for integrated appeals	6/20/13	7/31/13	(DSS), D.	OLCRA,
	b. Draft and finalize policies and procedures	7/1/13	9/1/13	Parrella	CEMA, O.

	c. Review and approval of policies and procedures (per State UAPA process)	?		(Mercer),	of Prot. &
	d. Identify and include customer service standards in the CHN contract	10/1/13	11/1/13	Project	Advoc., O.
	e. Identify and hire ombudsman for grievances	10/1/13	12/1/13	Coord./Assist.	of Health C. Adv.
4.	DMHAS Health Home (HH) Initiative: Define and finalize plan enrollment method for duals w/SPMI within Health Neighborhoods, enhanced ASO, and health homes	5/1/13	7/1/13	K. McEvoy, B. Halsey	C. Harington, DMHAS
5.	HN Formation Assistance Contractor			K. McEvoy,	OPM
	a. Identify contractor and secure sole source authority	5/15/13	6/3/13	Project	(Possible
	b. Develop, finalize, and execute contract	6/3/13	6/24/13	Coord./Assist.	Sole
	c. Contractor develops training and assistance plan for HNs	6/28/13	7/3/13	st.	Source)
	d. Contractor delivers training to potential HN	7/8/13	8/15/13		
6.	CMS Authorities	5/1/13	9/17/13	K. McEvoy,	Attorney
	a. Finalize choice of authorities with CMS	5/1/13	5/25/13	D. Parrella	General's
	b. Review SPA materials from other States	5/20/13	5/20/13	(Mercer)	Office
	c. Develop, finalize, and submit SPA(s)	7/31/13	7/30/13		

	d. CMS review and approval of SPAs		9/25/13		
7.	CMS MOU: Draft, negotiate, and execute CMS MOU	5/1/13	6/11/13	K. McEvoy, AG III TBD (DSS)	Governor' s Office
8.	Provider training and learning collaboratives			Project	
	a. Develop and disseminate guidance regarding care coordination contracts, antitrust, and data; disseminate relevant information based on cluster analysis of data	7/1/13	8/15/13	Coord./Assist.	
	b. HN training on topics such as person-centeredness and disability	1/15/14	3/15/13		
	c. Ongoing HN training and learning collaboratives	4/1/14	6/30/15		
9.	Outreach Plan			K. McEvoy,	D.
	a. Develop program messaging, member and provider outreach plan	6/1/13	7/1/13	Project	Dearborn
	b. Develop and finalize provider materials (HN and non-HN providers)	6/15/13	1/1/14	Coord./Assist.	
	c. Implement provider outreach plan (HN and non-HN providers)	7/1/13	5/1/14	st.	
	d. Develop and finalize member materials and mailings	11/1/13	12/1/13		
	e. Implement member outreach plan (initial enrollment, and ongoing	1/1/14	11/1/14		

	education and outreach)				
10.	Enrollment Broker - Xerox			K. Dowty,	DDS,
	a. Develop, finalize, and sign Xerox contract amendment	5/1/13	7/12/13	Project	DMHAS
	b. Client enrollment system - develop, test, and implement changes	7/15/13	12/13/13	Coord./Assi	
	c. File Transfer – test and implement – Xerox to MMIS, file transfer to HNs	9/15/13	11/15/13	st.	
	d. Develop enrollment protocols and procedures, call scripts	10/15/13	11/15/13		
	e. Staffing ramp-up and training	11/10/13	12/31/13		
	f. Review Xerox readiness for enrollment launch	11/15/13	12/2/13		
11.	MMIS - HP			M.	HP
	a. Define HP systems modification request (payment of various types, provider and client enrollment)	5/1/13	5/15/13	Heuschkel,	
	b. Cost out the HP systems modification request	5/15/13	5/30/13	S.	
	c. Develop and finalize definition document	5/20/13	8/15/13	Ouellette,	
	d. Programming and design of changes	9/20/13	11/10/13	U. Ganesan	
	e. Define HP/MMIS Federal reporting	10/1/13	12/1/13		
	f. Systems testing	11/10/13	12/1/13		

	g. Deploy changes	12/1/13			
12.	CHNCT			Judi	K.
	a. Amend CHNCT contract to include Model 1 responsibilities and support functions for Model 2	5/1/13	7/22/13	Jordan, K.	Brennan,
	b. Initiate Predictive Modeling using integrated data	8/1/13	9/25/13	McEvoy,	Sylvia
	c. Develop and implement member assessment tool and protocols	8/22/13	11/1/13	Project	Kelly/
	d. Integration of Medicare-Medicaid data with provider portal (develop procedures, testing, etc.)	10/1/13	1/1/14	Coord./Assi	Mary Ann
	e. CHNCT development of policies and procedures for Model 1	10/10/13	11/20/13	st.	Cyr/ Cory
	f. Readiness review of CHNCT Model 1 policies and procedures	12/1/13	12/20/13		Ludington
	g. CHN staffing for Model 1	1/1/14	4/1/14		(CHNCT)
	h. CHN staff training for Model 1	1/1/14	6/1/14		
13.	Financial Analysis			U.	Actuarial
	a. Review and refine analytic assumptions for calculation of APM 1 and APM 2 rates based on integrated Medicare/Medicaid data, beneficiary acuity and staffing requisites for providing care coordination (contingent	6/1/13	7/15/13	Ganesan,	consultant
				L. Voghel,	
				K. McEvoy,	

	on receipt of integrated 2011 data). Finalize APM 1 and APM 2 rates (including review and approval)			Fiscal Analysts	
	b. Develop projection of shared savings	6/12/13	8/15/13		
	c. Develop standards for distribution of shared savings among HN members	6/12/13	7/1/13		
	d. Calculation of shared savings, related quality measures, and distribution to HNs	(TBD - CMS)			
14.	EHR Cards			K. McEvoy,	Vendor
	a. Identify sole source vendor and secure approval	7/1/13	7/15/13	R. Zavoski,	
	b. Develop, finalize and execute contract	7/16/13	10/30/13	Project	
	c. Design card and define data elements	11/1/13	11/14/13	Coord./Assi	
	d. Vendor works with providers to set up card and readers	11/15/13	2/1/14	st.	
	e. Implementation of use of cards	4/1/14			
15.	Health Neighborhood Procurement			K. McEvoy,	Dep. Com.
	a. Develop and finalize RFP	4/1/13	6/30/13	R. Weiser,	K.
	b. Release RFP	7/1/13		B. Halsey,	Brennan
	c. Letters of Intent due (mandatory, non-binding)	7/15/13		AG III	(DSS), D.

	d. Proposal submissions	8/19/13		Contracts,	Parrella
	e. Proposal review, recommend and finalize awardees	8/19/13	9/19/13	Proj. Coor./Asst.	(Mercer)
16.	Health Neighborhood Contracts			K. McEvoy,	B.
	a. Develop contracts	7/10/13	8/10/13	K.	Parrella,
	b. Review/approval of contracts	8/10/13	10/1/13	Brennan,	Office of
	c. Negotiate contracts	9/19/13	10/4/13	U.	the
	d. Sign contracts	10/4/13	10/11/13	Ganesan,	Attorney
	e. HN Leads and Lead Care Management Agencies enroll in MMIS	10/11/13	10/18/13	Project	General
	f. HNs finalize care coordination policies and procedures, quality management strategies, etc	10/11/13	11/1/13	Coord./Assist.	
17.	Readiness Review with Health Neighborhoods			K. McEvoy,	R. Zavoski
	a. Develop review tools, questions, and procedures	10/1/13	11/1/13	D. Parrella	
	b. Conduct desk audit and on-site reviews of policies and procedures, systems, provider contracts, etc	11/1/13	11/15/13	(Mercer), Project	
	c. Provide feedback to HNs	11/15/13	11/22/13	Coord./Assist.	

	d. Conduct follow-up as needed and develop readiness report	11/22/13	11/29/13	st.	
	e. DSS Go/No Go-Live Decision for 1/1/14 open enrollment	12/3/13	12/3/13		
18.	Demonstration Go-Live / Enrollment			K. McEvoy	DMHAS,
	a. Develop and test files of clients for Demo (including identifying excluded populations, relevant subpopulations [such as HCBS waivers]. Data sources and specifics identified in earlier planning phases)	11/1/13	12/1/13	K. Brennan	DDS,
	b. Finalize enrollment file to be produced for outreach, transfer to Xerox	12/15/13	12/28/13	U. Ganesan,	CCC, D. Parrella
	c. Send notices to members regarding Demo enrollment	1/1/14	1/15/14	Project	(Mercer)
	d. Open enrollment period	1/1/14	3/31/14	Coord./Assist.	
	e. Develop test, and implement file transfer to HNs				
	f. Enrollment file transfer to HNs	3/25/14	ongoing		
	g. Client enrollment effective (in both Model 1 and Model 2) includes beginning of, and ongoing, assessment and care coordination activities	4/1/14	ongoing		
19.	Program Evaluation			K. McEvoy	CCC
	a. Develop program evaluation metrics			R. Zavoski,	CHNCT
	b. Identify sole source vender	12/1/13	12/15/13	Project	HP

	c. Secure sole source approval from OPM	12/16/13	1/1/14	Coord./Assi	
	d. Develop, finalize, and execute contract	1/1/14	2/15/14	st.	
	e. Develop and finalize program evaluation	2/15/14	4/1/14		
	f. Collect data	12/1/14	3/5/15		
	g. Report on identified quality measures	3/5/15	4/15/15		
	h. Interim program evaluation	4/15/15	6/15/15		
20.	Program Monitoring and Oversight			K. McEvoy	
	a. Develop monitoring and oversight plan of ongoing operations (Model 1 and 2; contractors)	8/1/13	11/20/13	R. Zavoski,	
	b. Implement monitoring and oversight plan	12/1/14	Ongoing	B. Halsey,	
	c. Ongoing technical support for Demo operations and staff from DSS	2/1/14	Ongoing	Project	
				Coord./Assi	
				st.	

Appendix F: Letters of Support



STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

April 22, 2013

Penny Williams, Grants Management Specialist
Centers for Medicare and Medicaid Services
Office of Acquisitions and Grants Management
7500 Security Boulevard, Baltimore, Maryland Mail Stop: B3-30-03
Re: Connecticut application, CFDA # 93.628

Dear Ms. Williams:

As interim Medicaid Director for the State of Connecticut Department of Social Services (DSS), I support and commend to your attention our application for Implementation Support for State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees (MMEs).

Connecticut MMEs face significant health status challenges related to chronic disease, incidence of Serious Mental Illness (SMI), cognitive impairment and co-morbidity of conditions. In addition, spending for Connecticut's 57,569 MMEs is 155% of the national average (\$53,500 per MME as compared with \$34,500), for a total cost of more than \$3.4 billion per year. The high incidence of MME's co-occurring medical and behavioral health conditions, and associated costs, presents unique challenges, and also opportunities for improvement.

Under the Demonstration, Connecticut will integrate non-medical, medical, and behavioral Medicare, Medicaid, and supplemental services for MMEs through two models that will rest upon the building blocks of its existing Medicaid and long-term care re-balancing reforms. DSS is well qualified to implement this Demonstration in support of MMEs in that it either directly or through ASOs has oversight of all Medicaid services; manages several of Connecticut's Medicaid waivers; and is steward of the Money Follows the Person program and the LTSS Rebalancing Strategy. DSS will directly manage program staff associated with the Demonstration, and will contract with key partners to implement various aspects of model design.

Federal support is needed for implementation activities that are detailed in our application. We affirm that Connecticut will adhere to all Demonstration requirements, including, but not limited to, beneficiary protections, use of funding, reporting and use of identified performance measures.

Thank you for the opportunity to apply for this essential support.

Best regards,

Kate McEvoy, Esq.

Interim Director of the Division of Health Services



Council on Medical Assistance Program Oversight
Complex Care Committee

Legislative Office Building Room 3000, Hartford CT 06106
(860) 240-0321 FAX (860) 240-5306 www.cga.ct.gov/med

TO: Penny Williams, Grants Management Specialist

Centers for Medicare and Medicaid Services

Office of Acquisitions and Grants Management

7500 Security Boulevard, Baltimore, MD

Mail Stop: B3-30-03

FROM: Sheila B. Amdur, Co-Chair

Complex Care Committee of the Council on Medical Assistance Oversight

Connecticut General Assembly

RE: Connecticut's Application for Implementation Support for State Demonstrations

to Integrate Care for Medicare-Medicaid Enrollees

DATE: April 22, 2013

The Connecticut Department of Social Services (DSS), which has responsibility for the state's Medicaid program, has worked closely with Connecticut General Assembly's Oversight Council's Complex Care Committee that oversees all Medicaid initiatives related to individuals with complex health conditions. I have co-chaired this Committee since its inception along with a member of the General Assembly.

The Complex Care Committee has a broad based membership of advocates, family members and consumers of those impacted by chronic illnesses, including those who are elderly, have serious mental illnesses, and developmental, physical and intellectual disabilities. The Committee also has a broad representation of providers from the Connecticut State Medical Society, hospitals, home care agencies, nursing homes, behavioral health providers, and representatives of state agencies who provide services to these populations.

The Committee worked closely with DSS on the initial application, and the major recommendations of the Committee were included in the application. During the past several months, we have worked intensely with DSS to review the operational plan, the care management and care coordination plan, quality outcomes, and financial models, which are addressed in this current Implementation application. We have begun to outline a framework to review the more detailed implementation planning over the next few months.

The current Implementation application is endorsed by the Committee and also has been received favorably by the Medical Oversight Council. DSS has been extraordinarily open and interactive with the diverse constituency groups to assure that Connecticut moves forward with a viable demonstration that will improve consumer experience, health outcomes of the people served, will be person centered, and will contribute to lowering the growth of healthcare spending.

We strongly recommend CMS' support of the application.